

may be re-issued by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
6769
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06757

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro				c. LENGTH OF STAY IN 1b 1 Month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cherry Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro			
				f. STREET ADDRESS None		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Moore				4. DATE OF DEATH Month 6 Day 13 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1874		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 13 Days 19 Hours 60	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Ohanlon				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James L. Moore Greensboro, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 10 1959 to June 13 1960 that (I) (we) last saw the deceased alive on June 12 1960 , and that death occurred at 9A M, from the causes and on the date stated above.							
22a. SIGNATURE Charles H. Stonesifer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type or print) Charles H. Stonesifer, M.D.	
				22d. ADDRESS Greensboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-16-60		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouclair				25a. REC'D BY REGISTRAR Greensboro, Md.		25b. REGISTRAR'S SIGNATURE Charles L. Haines	
				DATE JUN 17 '60			

1785

OFFICE OF THE

NO

October

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06732
5764 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL DENTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CLARK</u> Last <u>CLARK</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 5, 1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Tinley</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT (Address) <u>Howard Clark, Denton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis Scurie</u> 431X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Exhaustion</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>few mins.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dawson O. George M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 14, 1960</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood</u>		22d. LOCATION (City, town, or county) (State) <u>Harrington, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Vergil Hoover, Denton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR

the State Board of Health

VR A15 (4)
15M 9/59

06733

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Schleich</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Maryland</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orefield</u> d. STREET ADDRESS <u>None</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HENRIETTA</u> First <u>HERRMANN</u> Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-1888</u>
9. AGE (In years last birthday) <u>78</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. FATHER'S NAME <u>Christian Wolfe</u>		14. MOTHER'S MAIDEN NAME <u>Margaretta Loeck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>John Herrmann Maryland Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Cervix (infiltrative)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>171X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1960</u> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 2</u> 19 <u>60</u> to <u>June 1</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>May 31</u> 19 <u>60</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles H. Stonesifer</u>		22b. DATE SIGNED <u>6/1/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>		22d. ADDRESS <u>Greensboro, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-4-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grandview</u>		23d. LOCATION (City, town, or county) (State) <u>Allentown Pa</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulay Greensboro Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 2 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles H. Stonesifer</u>			

7000 0000 0000 0000

(10)

RECEIVED

10

10

10

10

10

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Federalsburg				c. LENGTH OF STAY IN 1b 53 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bridgeville Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Hulliger				4. DATE OF DEATH Month June Day 6 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1892	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 6 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Bern, Switzerland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Hulliger				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Mrs. Helen N. Hulliger		Address RFD Federalsburg	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Chronic DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1 INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 4 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Federalsburg				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dawson O. George				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Dawson O. George				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1960		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son				ADDRESS Federalsburg		24a. REC'D BY REGISTRAR DATE JUN 9 '60	
				24b. REGISTRAR'S SIGNATURE Clifton S. Hines			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF MEDICAL EXAMINER		11. SIGNATURE OF ATTENDING PHYSICIAN		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JURY		14. SIGNATURE OF JUDGE		15. SIGNATURE OF CLERK	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF DEPUTY SHERIFF		18. SIGNATURE OF CONSTABLE	
19. SIGNATURE OF ALDERMAN		20. SIGNATURE OF ALDERMAN		21. SIGNATURE OF ALDERMAN	
22. SIGNATURE OF ALDERMAN		23. SIGNATURE OF ALDERMAN		24. SIGNATURE OF ALDERMAN	
25. SIGNATURE OF ALDERMAN		26. SIGNATURE OF ALDERMAN		27. SIGNATURE OF ALDERMAN	
28. SIGNATURE OF ALDERMAN		29. SIGNATURE OF ALDERMAN		30. SIGNATURE OF ALDERMAN	
31. SIGNATURE OF ALDERMAN		32. SIGNATURE OF ALDERMAN		33. SIGNATURE OF ALDERMAN	
34. SIGNATURE OF ALDERMAN		35. SIGNATURE OF ALDERMAN		36. SIGNATURE OF ALDERMAN	
37. SIGNATURE OF ALDERMAN		38. SIGNATURE OF ALDERMAN		39. SIGNATURE OF ALDERMAN	
40. SIGNATURE OF ALDERMAN		41. SIGNATURE OF ALDERMAN		42. SIGNATURE OF ALDERMAN	
43. SIGNATURE OF ALDERMAN		44. SIGNATURE OF ALDERMAN		45. SIGNATURE OF ALDERMAN	
46. SIGNATURE OF ALDERMAN		47. SIGNATURE OF ALDERMAN		48. SIGNATURE OF ALDERMAN	
49. SIGNATURE OF ALDERMAN		50. SIGNATURE OF ALDERMAN		51. SIGNATURE OF ALDERMAN	
52. SIGNATURE OF ALDERMAN		53. SIGNATURE OF ALDERMAN		54. SIGNATURE OF ALDERMAN	
55. SIGNATURE OF ALDERMAN		56. SIGNATURE OF ALDERMAN		57. SIGNATURE OF ALDERMAN	
58. SIGNATURE OF ALDERMAN		59. SIGNATURE OF ALDERMAN		60. SIGNATURE OF ALDERMAN	
61. SIGNATURE OF ALDERMAN		62. SIGNATURE OF ALDERMAN		63. SIGNATURE OF ALDERMAN	
64. SIGNATURE OF ALDERMAN		65. SIGNATURE OF ALDERMAN		66. SIGNATURE OF ALDERMAN	
67. SIGNATURE OF ALDERMAN		68. SIGNATURE OF ALDERMAN		69. SIGNATURE OF ALDERMAN	
70. SIGNATURE OF ALDERMAN		71. SIGNATURE OF ALDERMAN		72. SIGNATURE OF ALDERMAN	
73. SIGNATURE OF ALDERMAN		74. SIGNATURE OF ALDERMAN		75. SIGNATURE OF ALDERMAN	
76. SIGNATURE OF ALDERMAN		77. SIGNATURE OF ALDERMAN		78. SIGNATURE OF ALDERMAN	
79. SIGNATURE OF ALDERMAN		80. SIGNATURE OF ALDERMAN		81. SIGNATURE OF ALDERMAN	
82. SIGNATURE OF ALDERMAN		83. SIGNATURE OF ALDERMAN		84. SIGNATURE OF ALDERMAN	
85. SIGNATURE OF ALDERMAN		86. SIGNATURE OF ALDERMAN		87. SIGNATURE OF ALDERMAN	
88. SIGNATURE OF ALDERMAN		89. SIGNATURE OF ALDERMAN		90. SIGNATURE OF ALDERMAN	
91. SIGNATURE OF ALDERMAN		92. SIGNATURE OF ALDERMAN		93. SIGNATURE OF ALDERMAN	
94. SIGNATURE OF ALDERMAN		95. SIGNATURE OF ALDERMAN		96. SIGNATURE OF ALDERMAN	
97. SIGNATURE OF ALDERMAN		98. SIGNATURE OF ALDERMAN		99. SIGNATURE OF ALDERMAN	
100. SIGNATURE OF ALDERMAN		101. SIGNATURE OF ALDERMAN		102. SIGNATURE OF ALDERMAN	

CHIEF CLERK

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6767

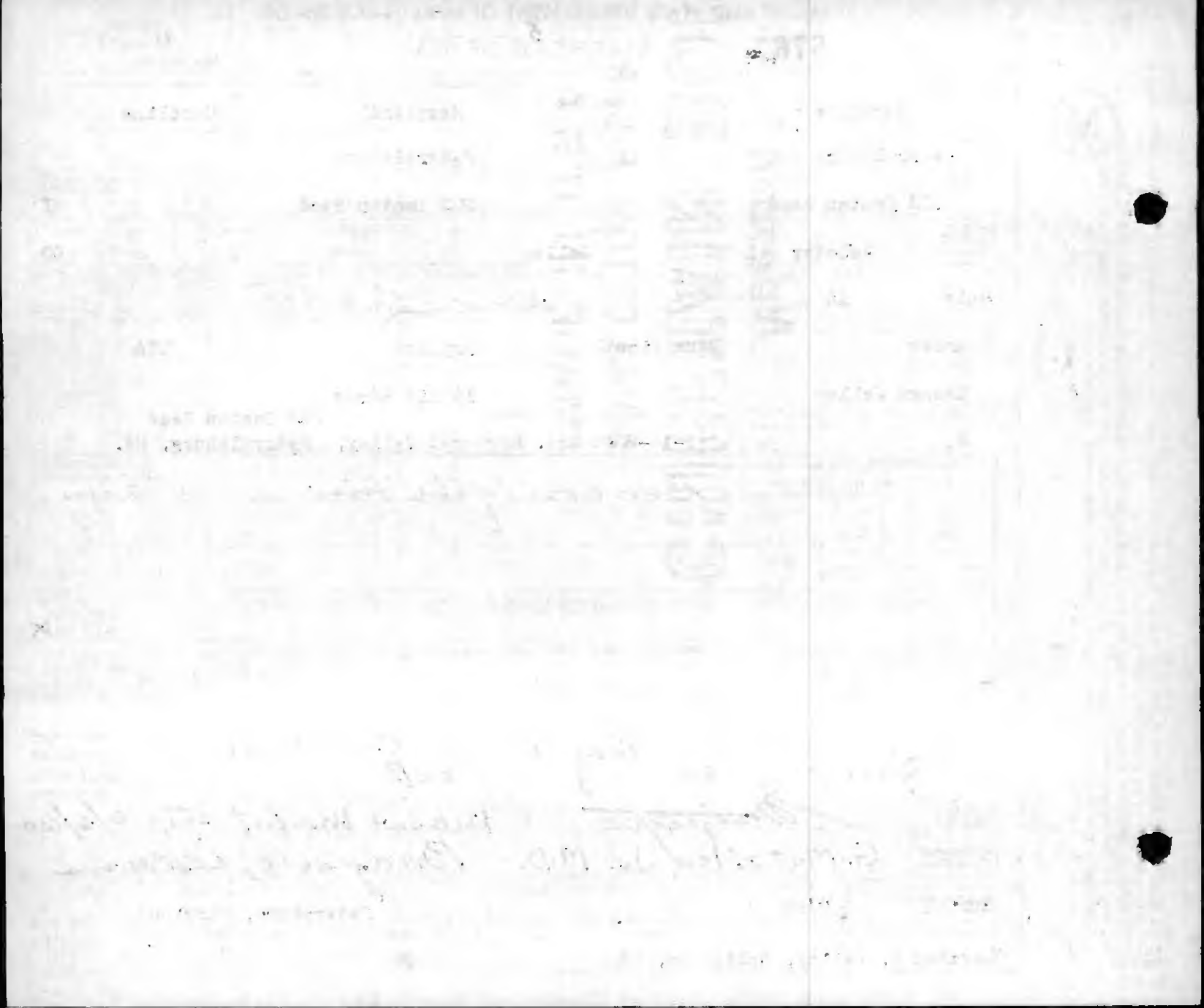
Item 9 Film G265 6-16-60 et

CERTIFICATE OF DEATH

06735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Feddersburg		c. LENGTH OF STAY IN 1b X Feddersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 Denton Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Webster Middle L Last Jolley		4. DATE OF DEATH Month 6 Day 3 Year 1960	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-1902
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 5 Days 18 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Educational	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Jolley		14. MOTHER'S MAIDEN NAME Lillie Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-14-3394	
17. INFORMANT Mrs. Margaret Jolley, Feddersburg, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the Liver DUE TO 581-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10 , 19 58 , to June 3 , 19 60 , that I last saw the deceased alive on June 3 , 19 60 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Metzger, Jr.		DATE SIGNED 6/6/60	
PHYSICIAN'S NAME (Type) G. Metzger, Jr. M.D.		ADDRESS (Street, city or town, state) Main Market St., Bridgeville, Delaware	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/7/60	22c. NAME OF CEMETERY OR CREMATORY Petersburg Cem -	22d. LOCATION (City, town, or county) (State) Petersburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md		24a. REC'D BY REGISTRAR DATE JUN 13 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6768
CERTIFICATE OF DEATH

06736

1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel c. LENGTH OF STAY IN 1b 40 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michele Middle LePore Last LePore		4. DATE OF DEATH Month 6 Day 18 Year 19 60	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1876
9 AGE (In years lost birthday) 83 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner	10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Joseph LePore		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Felice LePore Marydel, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal Cardiovascular/Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1, 1958 to June 18, 1960 , that (I) (we) last saw the deceased alive on June 18, 1960 , and that death occurred at 5AM , from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonestifer M.D.		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonestifer, M.D.		22d. ADDRESS Greensboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-22-60	23c. NAME OF CEMETERY OR CREMATORY Holy Cross	23d. LOCATION (City, town, or county) (State) Dover, Delaware
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Brainerd, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUN 22 '60	
		25b. REGISTRAR'S SIGNATURE Charles S. Kline	



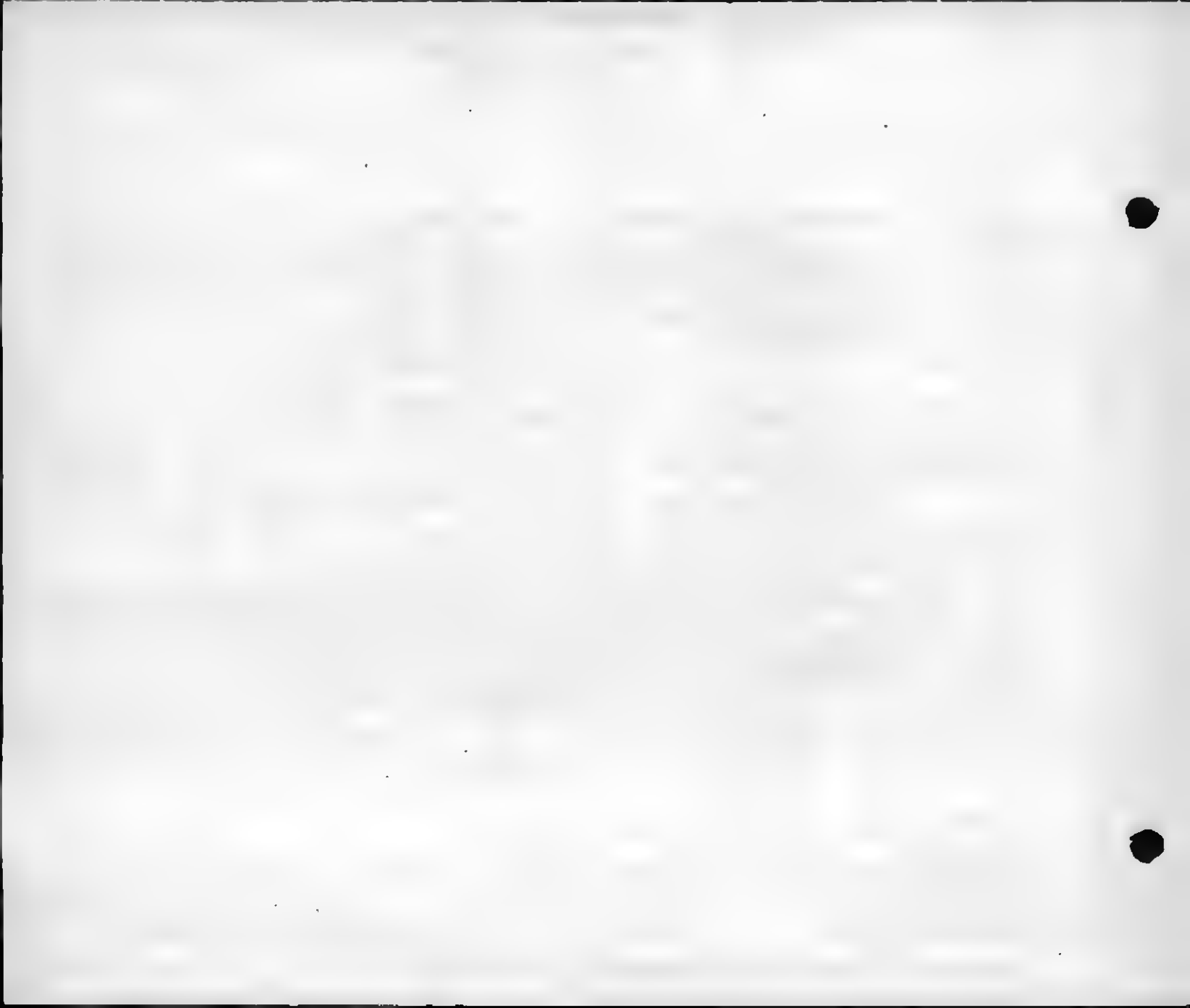
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5763

CERTIFICATE OF DEATH

Reg. Dist. No. 00734

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALLIE ANN MORGAN</u>				4. DATE OF DEATH Month Day Year <u>JUNE 25 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10, 1873</u>	9. AGE (In years last birthday) <u>87</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Bullock</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca C. Videw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Wm. Talmage Strong</u>				Address <u>Denton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos 6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 1960</u> to <u>June 23, 1960</u> , that I last saw the deceased alive on <u>June 23, 1960</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.				ADDRESS (Street, city or town, state) <u>Denton, Maryland</u>			
DATE SIGNED <u>June 28, 1960</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>June 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hoover</u> ADDRESS <u>Denton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06753

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Charles Street</u>		e. STREET ADDRESS <u>same</u>	
3. NAME OF DECEASED (Type or print) <u>Paul E. Nichols</u>		4. DATE OF DEATH June 27, 1960	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Nichols</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Collins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-22-6215</u>	
17. INFORMANT <u>Mrs. Chas Klein</u>		Address <u>Federalburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock - Hemorrhage</u> DUE TO <u>Sun shot wound to face</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Self Inflicted</u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asphyxiation</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Gun shot wound to face</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-27-1960</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>	
22a. LOCATION (City, town, or county) (State) <u>Federalburg Caroline Md.</u>		22b. DATE THEREOF <u>June 30, 1960</u>	
22c. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>		22d. NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold J. [illegible]</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. [illegible]</u>		24c. DATE SIGNED <u>June 28, 1960</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



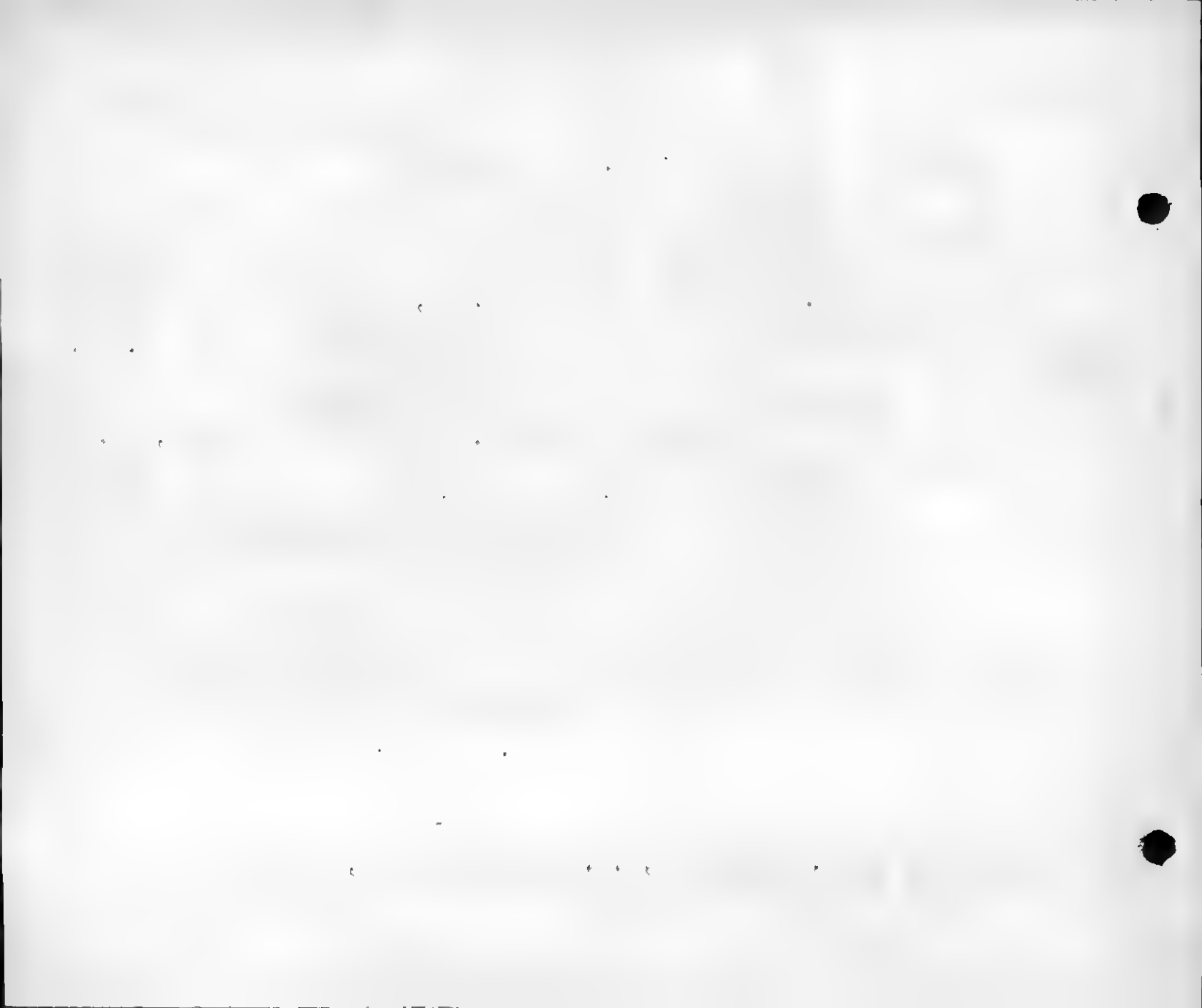
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
6771
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06740

1 PLACE OF DEATH a COUNTY Caroline MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE Maryland b COUNTY Caroline	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		c LENGTH OF STAY IN 1b 74 yr.	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely	
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d STREET ADDRESS None	
3 NAME OF DECEASED (Type or print) First James Middle Edward Last Ross		4 DATE OF DEATH Month June Day 26 Year 19 60	
5 SEX Male	6 COLOR OR RACE Cau.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 11, 1885
9 AGE (In years lost birthday) 74 yrs		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min 74	
10a USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Cannery Worker		10b KIND OF BUSINESS OR INDUSTRY Cannery	
11 BIRTHPLACE (State or foreign country) Delaware		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Charles Ross		14 MOTHER'S MAIDEN NAME Sarah Pippen	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 218-05-8287A	
17 INFORMANT Mrs. Katie Ross		Address Ridgely, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a m p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Nov. 10 1959 , to June 26 1960 , that (I) (we) lost saw the deceased alive on June 26 1960 , and that death occurred at 6 M, from the causes and on the date stated above.			
22a SIGNATURE Charles H. Stonesifer		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d ADDRESS Greensboro, Maryland	
23a BURIAL, CREMATON, REMOVAL (Specify) Burial		23b DATE THEREOF 6-30-60	
23c NAME OF CEMETERY OR CREMATORY Ridgely		23d LOCATION (City, town, or county) (State) Ridgely, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleais Greensboro, Md.		25a REC'D BY REGISTRAR DATE JUN 29 '60	
25b REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6772

CERTIFICATE OF DEATH

Reg. Dist. No.

06741

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural				c. LENGTH OF STAY IN lb 47 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Hynson				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Adolph Middle Reinhardt Last Seaman				4. DATE OF DEATH Month June Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1909	9. AGE (In years last birthday) 51 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Ridgeway, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Seaman				14. MOTHER'S MAIDEN NAME Mary Ischer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-1759		INFORMANT Address Mrs. Marie J. Seaman, Preston, Maryland, RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Embolus 443X DUE TO (b) Moderate Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Mild Hypertensive Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Moderately Severe Diabetes Mellitus - ? 6 yrs						INTERVAL BETWEEN ONSET AND DEATH ? minutes 10 yrs 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14 , 19 57 to 6/21 , 19 60 ; that I last saw the deceased alive on 6/14/1960 , and that death occurred at 6:40 A. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harley B. Plummer M.D.				ADDRESS (Street, city or town, state) Preston Md		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. H. B. Plummer				Preston Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1960		22c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		22d. LOCATION (City, town, or county) (State) Linchester, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE JUN 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1973

LETTER TO DEAR

1973

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06742**

6773

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Harmony				d. STREET ADDRESS Near Harmony			
3. NAME OF DECEASED (Type or print) First Emerson Middle Pennewell Last Willis				4. DATE OF DEATH Month June Day 18 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1896		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Penn Willis				14. MOTHER'S MAIDEN NAME Nellie Gullette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. M. Martha Layton, Preston, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Causes of Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dawson O. George				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-19-60	
EXAMINER'S NAME (Type) Dawson O. George				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 21, 1960		22c. NAME OF CEMETERY OR CREMATORY Concord Cemetery		22d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE JUN 22 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAKING STATE CERTIFICATE OF HEALTH - EASTERN 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE		DATE	